City of Fremont

Human Services Department

Referral Form

Date _____

☐ **Mental Health Counseling (YFS)** ☐ **Substance Use Counseling (YFS)** ☐ **Family Support/Case Mgt (FRC)**

Referred By (Name) _____ Phone _____ Email _____

Relationship with individual referred: ☐ Self ☐ Family member ☐ School Personnel

☐ Other Provider (specify)_____ ☐ Other_____

REFERRED INDIVIDUAL

Name (Last, First) _____ **DOB** (MM/DD/YY) _____

Preferred pronoun ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other _____

Gender ☐ Male ☐ Female ☐ Non-Binary ☐ Transgender MTF ☐ Transgender FTM ☐ Other_____

Home Address _____

Phone _____ Email_____

Health Insurance ☐ Medi-Cal (Policy # if known: _____) ☐ Other_____

School_____ Grade _____ Name of School Counselor _____

Parent/Guardian Name, *if applicable* (Last, First) _____Parent's Phone _____

Parent's email _____ Primary language spoken in household _____

Reasons for Referral_____

_____

_____

Individual's behaviors (check all that apply)			
☐	Aggressive, fighting, obscenities, anger control issues, suspension	☐	Anxious, worries, tense , nervous, fearful, timid
☐	Gang affiliation: member, wannabe, tagger	☐	Eating concerns, significant weight gain or loss
☐	Disruptive: difficulty focusing, sitting still, follow directions, etc.	☐	Depressed, crying, apathetic, withdrawn
☐	Drug/alcohol use: appears "spacey", talk about use with friend	☐	Self-destructive, self-mutilating
☐	Poor attendance, noticeable change in academic performance	☐	Socially related: shy, few/no friends, isolated
☐	Sexually acting out or inappropriateness	☐	Chronic illness, accidents, physical complaints
☐	Antisocial behavior: cheating, stealing, lying, etc.	☐	Poor self-concept: self-criticism, overly dependent
Stressors			
☐	Family changes or concerns at home, grief & loss	☐	History of Trauma, abuse

Please include any problems that the **family** is experiencing if you are aware of them *(Please ✓check all that apply):*

☐ Physical Health ☐ Medical Insurance ☐ Housing ☐ Substance Abuse ☐ Family Violence

☐ Economics Benefits ☐ Emergency Services (Food, clothes) ☐ Other _____

Requested **Location of Counseling** ☐ Telehealth (Phone/Video) ☐ School-site ☐ YFS Clinic (39155 Liberty Street, E-500, Fremont)

Available Day & Time for Counseling ☐ Mon_____ ☐ Tue_____ ☐ Wed_____ ☐ Thu_____ ☐ Fri_____ ☐ Sat_____

(Please indicate all days & times that the individual/family will be available for counseling so that we can quickly assign staff to follow up)

Discussion of Referral with Individual Referred ☐ *No* ■ *Yes*

If Yes, Individual's response ☐ *Agreed referral to YFS* ☐ *Undecided* ☐ *OK for YFS to call* ☐ *Other*_____

FOR URGENT OR CLIENT CRISIS REFERRALS, please contact school administrator immediately.
DO NOT fax referrals to YFS clinic for family relationship crisis session requests. Contact YFS directly at (510) 574-2100.

EMAIL OR FAX THIS FORM TO LAURIE LINSCHEID, LMFT

LLinscheid@fremont.gov Fax: (510) 574-2105